

Complete entire form and submit when sending medical documentation to Noridian. This will ensure the documentation is appropriately sorted and handled.

- I am sending this documentation to Noridian, as requested by:
 - Automated Development System (ADS): Letter Code: _____
 - Comprehensive Error Rate Testing (CERT)
 - Redetermination Documentation Request
 - Other: **If other, provide documentation requestor name.** _____
- The attached documentation was not requested by Noridian.
Provide explanation why documentation is being sent.

State services were provided: AK AZ ID MT ND OR SD UT WA WY

Beneficiary Information

Beneficiary First Name: _____
Beneficiary Last Name: _____
Medicare Number: _____
Date(s) of Service(s): _____
Internal Control Number (ICN): _____

Provider Information

Individual Provider Name: _____
Facility/Group Name: _____
Provider Transaction Access Number (PTAN): _____
National Provider Identifier (NPI): _____
Taxpayer Identification Number (TIN): _____

Fax documents to 701-277-7852

Noridian JF Part B
Attn: _____ (if applicable)
PO Box
Fargo, ND 58108 -

State and PO Box Numbers

AK 6703	OR 6702
AZ 6704	SD 6707
ID 6701	UT 6725
MT 6735	WA 6700
ND 6706	WY 6708